ICD-9-CM

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Coding

- What is Coding?
- A classifying system used to classify data and assign a representation for that data
- Clinical coding is the concept of coding diagnoses and procedures

Purpose of Coding

- Permit retrieval of information according to diagnoses and procedures
- Codes allow for easier retrieval
- Research

Purpose of Coding cont'd

- Statistical analysis
- Important part of reimbursement
  - DRG – Diagnosis Related Group
  - APC – Ambulatory Patient Classification

Nomenclature System

- **Nomenclature – a systematic listing of proper names.**

- **Disease nomenclature – listing of proper names for each disease, and each disease has its own code number (i.e. Parkinson's disease, parkinsonian syndrome, and paralysis agitans – different names for the same disease)**

Classification System

- **Classification – the grouping together of similar items**
- **Similar diseases and operations are grouped together under a single code (for example: ICD-9-CM)**

Early Classification of Diseases

- Hippocrates classified diseases according to part of the body affected

- Early 20th century in the U. S. , nomenclatures were developed for use in particular hospitals
  - Bellevue Hospital in New York City
  - Massachusetts General Hospital in Boston

Early Classification of Diseases cont'd

- Hospital specific nomenclatures difficult to compare information on diseases and operations across the country

- Standard Classified Nomenclature of Diseases - Standard Nomenclature of Diseases and Operations (SNDO) – developed to solve problem

Standard Classification of Diseases and Operations (SNDO)

- Classified diseases according to topography (site) and etiology (cause).
- Predominant coding system until 1950’s and 1960’s (too simplistic for increasing medical knowledge)
- During 1940’s on into 1960’s hospitals began using the International Classification of Diseases (ICD)

International Classification of Diseases (ICD)

- System derived from Bertillion Classification adopted in 1891
- Classified causes of death
- Published in 1979 (has not been totally revised yet)
- Revised every 10 years since 1891

International Classification of Diseases (ICD) cont'd

- Responsible parties for ICD-9-CM
  - The National Center for Health Statistics (NCHS) Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA)
  - Changes published each fall, and become effective October 1.

International Classification of Diseases (ICD) cont'd

- Cooperating Parties for ICD-9-CM
  - National Center for Health Statistics (NCHS) – responsible for changes to the disease classifications.
  - Centers for Medicare & Medicaid Services (CMS) – responsible for changes to the procedure classifications.

International Classification of Diseases (ICD) cont'd

- American Hospital Association (AHA) – maintains Central Office on ICD-9-CM
  - Answers coding questions
  - Publishes Coding Clinic – newsletter for official coding advice

International Classification of Diseases (ICD) cont'd

- American Health Information Management Association (AHIMA) – develops certification examination for experienced coders to become credentialed
  - Includes council on Coding Classification – provides leadership for the Association in the area of coding
  - Develops coding guidelines and deals with issues related to coding
  - Society for Clinical Coding – membership organization for individuals interested in coding

International Classification of Diseases (ICD) cont'd

- First revision done by the World Health Organization (WHO) for use throughout the world
- ICD modified for use in the U.S. (emphasized more acute , infective processes vs. chronic diseases)
- ICD-9-CM (CM= Clinical Modification)
- used in the U.S. for coding death certificates
- used in the U.S. for coding death certificates

International Classification of Diseases (ICD) cont'd

- Used in health care facilities (i.e. hospitals and clinics)
- Physician office coding arose because of a need for an easy, uniform, and accurate way for physicians to report services to third-party payors
- Current Procedural Terminology (CPT) developed for this purpose

ICD-9-CM Classification

- **What is ICD-9-CM?**
  - **Medical classification system used in the U. S. for the collection of information on disease and injury.**
- **Volume 1**
  - **Tabular List of Diseases**

ICD-9-CM Classification cont'd

- **Volume 2**
  - **Alphabetic Index of Diseases and Injuries**
- **Volume 3**
  - **Tabular List and Alphabetical Index of Procedures**

Volume I

- Tabular List of Diseases and Injuries
- 17 chapters
- Conditions that affect a specific body systems
- Two supplementary classifications
  - V and E codes

Volume I cont'd

- Three digit codes
  - Use of fourth and fifth digit subcategories
  - Codes appear in numerical order
- Appendices
  - Appendix A – Morphology and Neoplasms

Volume I cont'd

- Appendix B – Glossary of Mental Disorders
- Appendix C – Classification of Drugs
- Appendix D – Classification of Industrial Accidents According to Agency

Volume II

- **Alphabetic Index of Diseases and Injuries**
- **Main terms identify:**
  - **disease conditions or injuries**
  - **Subterms indicate site, type or etiology for conditions or injuries**

Volume II cont'd

- **Alphabetization Rules**
  - **Letter by letter alphabetization**
  - **Numerical entries**
- **Index Tables**
  - **Tables for systematic arrangement of subterms under main entries**

Volume III

- Tabular List and Alphabetic Index of Procedures
- Procedures consist of two digits, followed by a decimal point and one or two more digits

ICD-9 Conventions

- Instructional Notes
- General Notes
- Inclusion and Exclusion Notes
- Use Additional Code
- Code, If Applicable , Any Causal Condition First

Abbreviations in ICD-9

- Abbreviations
- NEC (Not elsewhere classified)
- NOS (Not otherwise specified)
- Cross-Reference Notes

ICD-9 Conventions cont'd

- See
- See Also
- See Category
- See Condition

Punctuation Marks in ICD-9

- Parentheses
- Square Brackets
- Colons

Relational Terms in ICD-9

- And
- Due To
- With

Uniform Hospital Discharge Data Set (UHDDS)

- Adopted in 1986
- Contains data elements for:
  - Personal identification
  - Date of birth
  - Sex
  - Race
  - Ethnicity
  - Residence
  - Hospital identification
  - Attending and operating physician
  - Diagnoses and procedures
  - Disposition of patient
  - Expected payment source (i.e. insurance, direct pay, etc.)

Uniform Hospital Discharge Data Set (UHDDS) cont'd

- Minimum core data for collection of individual hospital discharge data for Medicare and Medicaid
- Promulgated at the federal level, but is used as a standard in nonfederal and private sectors
- Widely used for over 20 years

Uniform Hospital Discharge Data Set (UHDDS) cont'd

- Reporting of inpatient data in:
  - Acute care hospitals
  - Short-term hospitals
- Minimum set of items based on:
  - Standard definitions w/consistent data for multiple users

UHDDS cont'd

- **Included items:**
  - **Easily identifiable**
  - **Readily defined**
  - **Uniformly recorded**
  - **Easily abstracted from the medical record**

UHDDS cont'd

- Data Items
- Principle Diagnosis
- Other Diagnosis
- Reporting for Other Diagnoses
- Admitting Diagnosis
- Procedures

UHDDS cont'd

- Relationship of UHDDS to Outpatient Reporting
  - Definition of principal diagnoses does not apply
  - No after study element is involved
  - Special rules apply for Medicare reporting
  - Admissions that occur within 72 hrs of outpatient care at the same facility
  - Principle diagnoses rule does apply

UHDDS cont'd

- **Ethical Coding and Reporting**
  - **Important in determining payment for health care**
  - **Accurate and ethical coding depends on following all instructions in coding manual and official guidelines developed by AHA's quarterly Coding Clinic**
  - **Correct selection of conditions that meet criteria for UHDDS and official guidelines**
  - **Overcoding and over-reporting – result in higher payment - fraud**
  - **Undercoding – financial loss for institution**
  - **Unacceptable codes – as principle diagnosis**

Medical Record as a Source Document

- Major source document for coding and reporting diagnoses and procedures
- Needed for accurate coding
- Contain a variety of reports
- Discharge summary